



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Subsequent Injury Fund (MS-15)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4418 | F: (512) 804-4759 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

SIF Reimbursement Request Form – Pharmaceutical

I. REQUEST

1. Reimbursement Amount Requested	2. Request Date
3. Contact Name	
4. Contact Phone Number	5. Contact Email Address

II. CLAIM INFORMATION

6. Injured Employee's Name (First, Middle, Last)	
7. Employee's Date of Injury	8. DWC Claim Number

III. PAYEE (Insurance carrier)

9. Name of Payee	10. Payee Federal Tax ID No.
11. Address of Payee (Street or P.O. Box, City, State, ZIP Code)	

IV. TELL US THE REASON FOR SEEKING THIS REIMBURSEMENT

<p>12. Describe the reimbursement request.</p> <ul style="list-style-type: none"> • How was this injury determined to be non-compensable? When was compensability disputed? • How was it determined: <ul style="list-style-type: none"> ○ did a final order or decision find the injury non-compensable; or ○ did the claimant fail to respond within 1 year of dispute?
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VI. REQUIRED ATTACHMENTS

Include the following documents with each request.

- A detailed payment record that includes the following:
 - date of payment;
 - amount of payment;
 - description of service; and
 - dates of service.

- Documentation showing pharmaceutical services were provided and paid (DWC Form-066, medical bills, or explanation of benefits (EOBs)).
- Notice of denial of compensability or liability and refusal to pay benefits (PLN01).
- Final order or decision on compensability, if applicable.
- W-9 for the insurance carrier.

Unless otherwise requested, please limit submission to the above items.

To expedite review of this request, please fax to (512) 804-4759 or use electronic transfer.

Frequently Asked Questions

Who can file DWC Form-098?

Insurance carriers and their authorized representatives should use this form to expedite the insurance carrier's request for reimbursement from the subsequent injury fund.

Can I use this form to submit a request for reimbursement of any overpayments?

Forms are specific to the cause of the unrecoupable reimbursable overpayment. DWC Form-098 should be used when initial pharmaceutical coverage was provided for an injury that was later determined to be non-compensable.

When can I file DWC Form-098?

Requests for reimbursement for pharmaceutical benefits must be filed the same or following fiscal year after a determination that the injury is not compensable. A fiscal year begins each September 1st and ends on August 31st of the next calendar year. For example, if an injury is determined to be not compensable during the fiscal year from September 1, 2017, through August 31, 2018, the request for reimbursement must be submitted by August 31, 2019.

What statutes and rules apply to this type of reimbursement?

Texas Labor Code §§403.006(b)(3) and 413.0141 and 28 Texas Administrative Code §§116.11(a)(6), 116.11(g), and 134.501(a).

How do I submit this request by electronic file transfer?

If you already have an account with DWC, you may use the same electronic file transfer account. If you need an account, please contact our office.

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